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IN THE

Supreme Court of the United States

OCTOBER TERM, 1999

JOHN DOE and RICHARD SMITH,
Petitioners,

v.

MUTUAL OF OMAHA INSURANCE COMPANY,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF, AND BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS, OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA; NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS; NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS; AMERICAN NURSES ASSOCIATION; HIV QUALITY CARE NETWORK; AND AMERICAN PUBLIC HEALTH ASSOCIATION

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MOTION OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA *ET AL.* FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF SUPPORTING PETITION FOR CERTIORARI

Pursuant to Rule 37.2(b) of the Rules of the Supreme Court of the United States, the Infectious Diseases Society of America, National Alliance of State and Territorial AIDS Directors, National Association of Public Hospitals and Health Systems, American Nurses Association, HIV Quality Care Network and American Public Health Association ("Health Care and Public Health Authorities") request leave to file the attached *amicus curiae* brief in support of the petition of John Doe and Richard Smith for a writ of certiorari. The Petitioners have consented to the filing of this

brief, but counsel for Mutual of Omaha Insurance Company ("Mutual") has informed the undersigned that the Respondent does not consent.[1]

This case raises an issue that goes to the heart of the Americans With Disabilities Act ("ADA"): whether the statute applies to terms and conditions of health insurance policies that discriminate on their face against policyholders with Human Immunodeficiency Virus ("HIV") infection. Health Care and Public Health Authorities bring a broader perspective than the parties to their assessment of Mutual's practice of restricting coverage of Acquired Immune Deficiency Syndrome ("AIDS") and "AIDS-related conditions" (Pet. App. 20a). Health Care and Public Health Authorities include infectious disease specialists and other health care professionals, hospitals, and clinics that are in the forefront of medical treatment of persons with HIV/AIDS. They also include public health officials and other public health professionals who protect the public from the further spread of HIV. Because of their expertise in HIV medicine and public health dimensions of the pandemic, they are uniquely suited to apprise the Court of how Mutual's AIDS caps affect policyholders with HIV infection or AIDS and the Nation's battle to contain HIV and AIDS.

To assist the Court in evaluating the petition for certiorari, Health Care and Public Health Authorities discuss in the attached *amicus* brief certain points not developed in the petition for certiorari. *First,* the brief demonstrates how HIV/AIDS health insurance caps block persons with HIV from receiving adequate health care and, therefore, interfere with HIV-infected policyholders' ability to maintain their health and remain full participants in the workforce and in their communities. Thus, Mutual's practice undermines the ADA's goal of removing discriminatory obstacles to the

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[1] A letter from counsel for the Petitioners granting consent and a letter from counsel for the Respondent withholding consent have been filed separately with the Clerk of the Court.

independence of persons with disabilities and their full participation in society, 42 U.S.C. § 12101(a)(8).

Second, the ADA's goals include reducing burdens on taxpayers resulting from discrimination that forces persons with disabilities into dependency. 42 U.S.C. § 12101(a)(9). The *amicus* brief discusses how HIV/AIDS caps in private health insurance increases costs to taxpayers by shifting more of the burden of the HIV pandemic onto publicly-funded health care and health insurance programs, and by exacerbating the public health threats of tuberculosis and drug-resistant strains of the HIV virus.

Third, the brief demonstrates how a cap on "AIDS-related conditions" is a classic form of discrimination based on disability because the cap limits coverage of the cost of treating a plethora of illnesses when they occur in policyholders with HIV/AIDS but not when those same illnesses occur in other policyholders. The lower court's conclusion that pneumonia, cancer and other such illnesses are not the same illnesses when they occur in HIV-positive and HIV-negative patients is unsupported by medical science.

Fourth, the *amicus* brief explains that this case presents an excellent opportunity for the Court to resolve the issue of HIV/AIDS health insurance caps. Mutual's stipulation in this case that it would offer no cost-based defense for its practice simply reflects reality; the cost of treating HIV/AIDS is comparable to or less than the cost of treating other serious illnesses, and poses no threat to the solvency of insurers or to the availability or affordability of health insurance. The Court of Appeals' decision has created uncertainty as to the legal status of HIV/AIDS health insurance caps that is intolerable to health care professionals as well as to their patients.

Health Care and Public Health Authorities respectfully submit that the Court should be apprised of these important dimensions of this case in deciding whether to

grant the petition for certiorari. Therefore, they request that their motion for leave to file the attached brief be granted.

Respectfully Submitted,

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 1

ARGUMENT 3

I. Insurance Discrimination Targeting HIV-Related Medical Care Contradicts the ADA's Goal of Removing Barriers to Independence and Full Participation in Society by Persons With Disabilities 3

II. Health Insurance Caps on HIV/AIDS Undermine the ADA's Goal of Reducing Unnecessary Burdens on Taxpayers by Increasing Costs of Public Benefit and Health Care Programs and By Creating Public Health Risks 9

III. Limiting Coverage of Medical Care Related to a Disability Such as HIV/AIDS Strikes at the Heart of the ADA 12

IV. This Case Presents a Good Opportunity to Resolve the Uncertainty Over the Legality of AIDS Caps Under the ADA 17

CONCLUSION 20

APPENDIX: STATEMENTS OF INTEREST OF *AMICI CURIAE* A1

TABLE OF AUTHORITIES

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INTEREST OF THE *AMICI CURIAE*

This *amicus curiae* brief is submitted by the Infectious Diseases Society of America, National Alliance of State and Territorial AIDS Directors, National Association of Public Hospitals and Health Systems, American Nurses Association, HIV Quality Care Network, and American Public Health Association in support of the petition of John Doe and Richard Smith for a writ of *certiorari*.[1] *Amici* are national organizations representing health care providers, hospitals and outpatient clinics, public health officials and public health professionals. *Amici*'s members provide medical care and treatment to persons infected with the Human Immunodeficiency Virus ("HIV") and persons with Acquired Immune Deficiency Syndrome ("AIDS") and protect the public from the further spread of HIV and AIDS. The statements of interest of the *amici* are included in the appendix to this brief.

The Respondent has not consented to the filing of this brief. It is being submitted with a motion for leave to file.[2]

SUMMARY OF ARGUMENT

This case raises an issue of great public importance that goes to the heart of the ADA. Mutual of Omaha Insurance Company ("Mutual") has capped coverage for medical treatment related to HIV/AIDS or "AIDS-related conditions" (hereinafter "AIDS caps") at levels far below the coverage it provides for policyholders without HIV infection. Mutual's practice undermines the ADA's goals of

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[1] This brief has been authored in its entirety by undersigned counsel for the *amici*. No person or entity other than the named *amici* and their counsel made any monetary contribution to the preparation and submission of this brief.

[2] A letter from counsel for the Petitioners granting consent and a letter from counsel for the Respondent withholding consent have been filed separately with the Clerk of the Court.

"full participation, independent living, and economic self-sufficiency" of persons with disabilities, 42 U.S.C. § 12101(a)(8), and reduction of the cost to taxpayers of public programs to care for unnecessarily dependent disabled persons, § 12101(a)(9). The caps substantially impede the ability of policyholders with HIV to obtain adequate medical care and, thus, their ability to be self-sufficient, to remain in the workplace and otherwise to fully participate in their communities. As policyholders with HIV become sicker, Mutual's AIDS caps will accelerate their decline by limiting coverage of virtually all their health care needs. AIDS health insurance caps increase costs to taxpayers by forcing more HIV-positive policyholders to rely on publicly funded health care and cash benefit programs. Such caps also exacerbate public health risks, particularly tuberculosis and transmission of strains of HIV that have become resistant to current antiretroviral medications because of interruptions in treatment.

The Court of Appeals held that Mutual's AIDS caps do not constitute disability discrimination because Mutual has restricted coverage for medical needs related to this particular disability but has not denied all coverage for persons with HIV/AIDS. Whether a coverage cap that singles out medical care related to a disability is disability-based discrimination is an important question about the scope of the ADA that warrants the Court's review, particularly in light of the broad reading of the ADA's prohibition of disability discrimination in *Olmstead v. L.C.*, __ U.S. __, 119 S. Ct. 2176 (1999). Even under a narrower reading of the ADA, Mutual's AIDS caps are discriminatory because they deny coverage of many diseases when they occur in HIV-infected policyholders while covering those same diseases when they occur in policyholders without HIV infection, thereby treating similarly situated policyholders differently, solely on the basis of disability.

Resolution of the questions presented by this case will resolve the legality of HIV/AIDS caps under the ADA,

not only for Mutual's current insurance policies but also for the industry generally. The ADA permits disparate treatment of persons with disabilities in insurance when based on a difference in costs, but Mutual concedes that there is no cost-related justification for its AIDS caps. Mutual's stipulations reflect reality: the cost of treating HIV infection and AIDS is comparable to, or lower than, the cost of treating many other serious illnesses. The lower court's decision may lead to a resurgence of AIDS caps and creates substantial uncertainty as to their legality. This Court's review is urgently needed to resolve this uncertainty.

ARGUMENT

I. Insurance Discrimination Targeting HIV-Related Medical Care Contradicts the ADA's Goal of Removing Barriers to Independence and Full Participation in Society by Persons With Disabilities.

Congress' aims in enacting the ADA included "full participation, independent living, and economic self-sufficiency" of persons with disabilities, 42 U.S.C. § 12101(a)(8). By expressly including insurance in Title III of the ADA and defining discrimination in Title I to include discrimination in employment-related fringe benefits, Congress recognized that discrimination in insurance is a major obstacle to the ability of persons with disabilities to be independent and to contribute to society, and increases their dependence on taxpayer-funded public programs.[3]

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[3] Although this case arises under Title III of the ADA (which applies to goods and services provided by privately owned or operated public accommodations), the Court of Appeals' analysis appears to apply with equal force to discrimination in employer-provided health insurance and other fringe benefits under ADA Title I. *See* 42 U.S.C. § 12112(a) & (b)(2) (prohibiting discrimination in the terms, conditions and privileges of employment, including employee fringe benefits).

Commenting on Congress' intent to include the insurance industry within the scope of Title III of the ADA, one federal court observed:

> There can hardly be a "good" or "service" more central to the day-to-day life of a seriously disabled person than insurance -- for it is often insurance coverage that will determine a disabled person's ability to prevent the disability from limiting his or her participation in society.

Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 427 (D. N.H. 1996) (*quoting Parker v. Metropolitan Life Ins. Co.*, 99 F.3d 181 (6th Cir. 1996), *vacated, op. on reh'g*, 121 F.3d 1006 (*en banc*), *cert. denied*, 522 U.S. 1084, 118 S. Ct. 871 (1998)).

Because health is critical to one's ability to function, health insurance is particularly critical for persons with disabilities. In its 1988 report to Congress, the National Council on Disability (formerly the National Council on the Handicapped) declared: "Access to health insurance is certainly one key toward independent functioning." National Council on Disability, *On the Threshold of Independence* 55 (1988) <http://www.ncd.gov/publications/threshold.html>. Two years earlier, the Council had recommended that Congress enact a comprehensive new civil rights law to protect persons with disabilities and that insurance discrimination be included in the new law's scope. National Council on Disability, *Toward Independence* 18 (1986) <http://www.ncd.gov/publications/toward.html>. The National Council on Disability played a major role in the formulation of the ADA. 136 Cong. Rec. S9692 (July 13, 1990) (statement of Senator Harkin). In *Sutton v. United Air Lines, Inc.*, 119 S. Ct. 2139, 2147-48 (1999), this Court relied on the 1986 and 1988 reports of the Council in determining the intent of another provision of the ADA, the

Congressional finding in 42 U.S.C. § 12101(a)(1).

Discrimination in health insurance is particularly corrosive of the independence of persons with HIV/AIDS and their full participation in society. HIV infection "affects the need for ... health care," *Bragdon v. Abbott,* 524 U.S. 624, 656 (1998) (Ginsburg, J., concurring), in far-reaching ways. The course of HIV infection -- when and perhaps even whether the infected person will become incapacitated by illness -- is determined by access to prompt, continuous medical treatment.[4] Recent advances in medical treatments are enabling many persons with HIV to stay relatively healthy and to remain productive members of the workforce and participants in their communities. AIDS caps in health insurance prevent persons with HIV from taking full advantage of these treatment advances and increase the likelihood that their independence and ability to function will be curtailed by illness and even death.

HIV-infected persons who are uninsured or under-insured have less access to medical care.[5] A recent major study of health care utilization by HIV-positive adults found that having no insurance, and having Medicaid rather than private insurance, were among the most important explanations for deficient access to and utilization of health care services.[6] The study concluded that "being uninsured and having HIV is a serious problem and places the

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[4] *See, e.g.,* Dennis R. Schaberg, *Case Commentary,* Hospital Practice, Dec. 15, 1998, at 69-71; Joel E. Gallant et al., *The Impact of Prophylaxis on Outcome and Resource Utilization in Pneumocystis carinii Pneumonia,* 107 Chest 1018, 1022 (1995). *See also* John G. Bartlett, *1999 Medical Management of HIV Infection* 3 (antiretroviral therapy, care by a physician with HIV expertise, and prophylaxis for HIV-related opportunistic infections are shown to prolong survival of HIV-infected patients).

[5] Robert Steinbrook, *Caring for People with Human Immunodeficiency Virus Infection,* 339 New Eng. J. of Med. 1926, 1927 (1998).

[6] Martin F. Shapiro et al., *Variations in the Care of HIV-Infected Adults in the United States,* 281 J.A.M.A. 2305, 2314 (1999).

individual at risk of not obtaining adequate care."[7] Other recent studies have found that uninsured HIV-infected persons are less likely to receive outpatient medical care than insured HIV-infected patients,[8] and more than twice as likely as those with insurance to report having no usual place of medical care.[9]

HIV medications, which delay the onset of AIDS and improve quality of life, are a key element in HIV treatment and should be started early in the disease's history.[10] A major recent study found that HIV-positive persons with no insurance or with Medicaid were significantly less likely than those with private insurance ever to have received antiretroviral therapy.[11] Even if some individuals can obtain the anti-HIV medications without health insurance, through a State AIDS Drug Assistance Program (ADAP),[12] the benefit of those medications cannot be realized without an ongoing relationship with a primary care provider who is an HIV

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[7] *Id.* at 2314.

[8] Mitchell H. Katz et al., *Insurance Type and Satisfaction with Medical Care Among HIV-Infected Men*, 14 J. of A.I.D.S. and Hum. Retrovirology 35, 41 (1997); William E. Cunningham et al., *Access to Community-Based Medical Services and Number of Hospitalizations Among Patients With HIV Disease: Are They Related?*, 13 J. of A.I.D.S. and Hum. Retrovirology 327, 334 (1996).

[9] Centers for Disease Control and Prevention, *Health Insurance Coverage and Receipt of Preventive Health Services -- United States, 1993*, 273 J.A.M.A. 1083, 1083 (1995).

[10] Steven G. Deeks & Paul A. Volberding, *Antiretroviral Therapy, in The Medical Management of AIDS* 97, 97, 109 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[11] Shapiro, *supra* note 6, at 2312-13.

[12] ADAP programs provide AIDS medications for lower-income persons who are uninsured or who have inadequate prescription-drug coverage. State ADAP programs provide only prescription drugs, not other medical coverage or services. Some State programs cover only limited HIV-related drugs, limit eligibility on the basis of income and other factors, and have waiting lists. United States General Accounting Office, *HIV/AIDS Drugs; Funding Implications of New Combination Therapies for Federal and State Programs*, GAO/HEHS-99-2, at 6, 17-18 (October 1998) ("GAO Report"), App. I; Steinbrook, *supra* note 5, at 1927.

expert. A patient on anti-HIV drug therapy needs frequent follow-up appointments with an HIV expert to monitor the drugs' effectiveness and to diagnose and treat the numerous, potentially dangerous side effects that the patient may experience.[13] Further, consistent adherence to antiretroviral therapy is essential to its effectiveness, because non-adherence can cause the virus to mutate into drug-resistant strains. Non-adherence to a particular drug therapy can even result in viral resistance to other, untried antiretroviral therapies.[14] An ongoing patient-provider relationship has been shown to be one of the most important factors influencing patients' adherence to anti-HIV drug regimens, particularly because of the complexity of the regimens and their side effects.[15] Individuals without private health insurance are less likely to have an ongoing relationship with a primary care provider.[16]

Public health insurance programs – Medicaid and Medicare – do not provide an adequate alternative to many individuals who are subject to an HIV/AIDS cap in their private insurance plans. Many HIV-positive individuals are ineligible for Medicaid because they are not sick enough or do not have a sufficiently low income to qualify for Medicaid.[17] Medicare is tied to eligibility for Social Security

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[13] Deeks & Volberding, *supra* note 10, at 97, 99; Nancy R. Reynolds, *Initiatives to Get HIV-Infected Patients to Adhere to Their Treatment Regimens*, Drug Benefit Trends (Nov. 1998) at 23, section 2 <http://www.medscape.com/SCP/DBT/1998/v10.n11/d3361. reyn/d3361. reyn-01.html>.

[14] Reynolds, *supra* note 13, at section 1; Frederick M. Hecht & Margaret A. Chesney, *Adherence to HIV Therapy, in The Medical Management of AIDS* 117, 117 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[15] Reynolds, *supra* note 13, at sections 2, 4.

[16] Cunningham, *supra* note 8, at 334; Sharon L. Zucconi et al., *Impact of Immunosuppression on Health Care Use by Men in the Multicenter AIDS Cohort Study (MACS)*, 7 J. of A.I.D.S. and Hum. Retrovirology 607, 613-14 (1994); Jesse Green & Peter S. Arno, *The "Medicaidization" of AIDS: Trends in the Financing of HIV-Related Medical Care*, 264 J.A.M.A. 1261, 1265 (1990).

[17] GAO Report, *supra* note 12, at 6; Steinbrook, *supra* note 5, at 1927.

Disability Insurance ("SSDI") benefits; like Medicaid, therefore, Medicare is only available to persons who are very ill. 42 U.S.C. § 423(d)(2)(A).

The record in this case illustrates the painful, risky choices that Mutual's AIDS caps have forced on the Petitioners. Mr. Doe and Mr. Smith have participated in experimental drug trials and forgone medical care to try to save coverage dollars for their future needs. (Pet. App. 34a-35a (Mr. Doe), 40a-41a (Mr. Smith).)

As HIV progressively ravages the immune system, Mutual's AIDS caps will accelerate the decline of HIV-positive policyholders because the caps will apply to more and more of the medical care that the HIV-positive policyholder needs. The Court of Appeals' pronouncement that "[Mutual's] policies give ... people [with AIDS] as much coverage for [medical] needs [unrelated to AIDS] as the policies give people who don't have AIDS" (Pet. App. 3a) fails to appreciate the broad and devastating impact of Mutual's caps, which apply to

> any expense relating to AIDS or ARC (which can include, but is not limited to, all expenses related to infection with HIV including antiviral or antiretroviral drugs or therapies, prophylaxis for prevention of opportunistic infection or illness, treatment for any opportunistic infection or resulting illness, or any diagnostic testing for HIV or AIDS).

(Pet. App. 20a-21a.) Persons with more advanced HIV infection or AIDS are subject to a staggering array of bacterial, viral, and fungal infections; and debilitating or life-threatening neoplastic, neurological, hematologic, oral, ophthalmic, gastrointestinal, pulmonary, gynecological, dermatological, and other diseases and complications.[18]

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[18] Anthony S. Fauci and Clifford Lane, *Human Immunodeficiency Virus (HIV) Disease: AIDS and Related Disorders, in* 2 *Harrison's Principles*

"Virtually every organ in the body is vulnerable to disease ... as a consequence of HIV infection...."[19] Mutual's caps restrict coverage of this plethora of diseases. Thus, while a policyholder with HIV might be able to obtain unrestricted coverage of a broken leg (to use the lower court's example, Pet. App. 7a) -- unless the recovery from the broken leg were complicated by a compromised immune system or HIV-related illnesses -- most other medical needs of a policyholder with advanced HIV infection or AIDS are likely to fall under the cap because they will be directly or indirectly related to the HIV infection.

Thus, Mutual's caps force persons such as Mr. Doe and Mr. Smith to endanger their health and eviscerate the ADA's goal of removing discriminatory barriers to the independence and self-sufficiency of persons with disabilities.

II. Health Insurance Caps on HIV/AIDS Undermine the ADA's Goal of Reducing Unnecessary Burdens on Taxpayers by Increasing Costs of Public Benefit and Health Care Programs and By Creating Public Health Risks.

HIV/AIDS caps in private health insurance also pose a significant financial burden on the public fisc, by forcing persons with HIV/AIDS into otherwise unnecessary dependency on public health care and cash benefit programs. This result is contrary to the ADA's aim of reducing the "costs [to] the United States [of] billions of dollars in unnecessary expenses resulting from dependency and nonproductivity" caused by discrimination. 42 U.S.C. § 12101(a)(9).

Without adequate health care from the onset of an HIV or AIDS diagnosis, an infected person's health is likely

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of Internal Medicine 1791, 1819-1845 (Anthony S. Fauci et al. eds., 14th ed. 1998).

[19] *Id.* at 1040.

to deteriorate at a much more rapid rate, resulting in debilitating illnesses. Persons who otherwise could remain in the workplace perhaps for many years will be forced to stop working and resort to the SSDI or Supplemental Security Income ("SSI") programs; Medicaid and/or Medicare; and/or their State's ADAP program. It would fly in the face of Congress' stated intent to countenance a form of insurance discrimination that would exacerbate the already substantial burden on these public programs.

Even now, HIV-positive patients are three times as likely to be insured by Medicaid as the general population, and nine times as likely to have Medicare coverage.[20] The federal government pays more than half the costs for HIV/AIDS treatment in the United States.[21] Further, HIV-positive individuals with public insurance and those with no insurance depend largely on public hospitals and clinics.[22] As medical science advances and new drug treatments for HIV become available, ADAP programs must pay increasing amounts to supply more drugs to more people.[23] Although the costs of anti-HIV medications are offset by savings in other medical costs, particularly hospitalization costs (*see infra*, page 11), ADAP programs cover only prescription drugs and, therefore, cannot capture the offsetting cost reductions.

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[20] Samuel A. Bozzette et al., *The Care of HIV-Infected Adults in the United States*, 339 New Eng. J. of Med. 1897, 1902 (1998).

[21] GAO Report, *supra* note 12, at 2.

[22] Green & Arno, *supra* note 16, at 1264 (1990) (AIDS patients with Medicaid are much more likely than privately insured AIDS patients to be hospitalized in public hospitals); Katz, *supra* note 8, at 41 (publicly insured men were more likely than others to receive care in public clinics (53.2% as compared to 19.4%)); John A. Fleishman & Vincent Mor, *Insurance Status Among People With AIDS: Relationships With Sociodemographic Characteristics and Service Use*, 30 Inquiry 180, 180, 185 (1993) (95% of the uninsured and the publicly insured rely on public hospital clinics as their source of medical care).

[23] GAO Report, *supra* note 12, at 8, 10, 12, 13.

Uninsured persons impose additional costs on society because they are less likely to receive preventive health services, which means that the health care they eventually require is more expensive.[24] Antiretroviral drug therapies result in an overall reduction in the costs of treating HIV infection because they reduce the need for inpatient and acute care.[25] A study at The Johns Hopkins Medical Institutions found that the failure among many HIV-positive persons to receive preventive treatment for *Pneumocystis carinii* pneumonia ("PCP") not only shortened their lives needlessly, but also greatly increased medical costs. The researchers estimated that such preventive treatment could have averted nearly $5 million in hospital costs in Maryland in 1991.[26]

HIV/AIDS health insurance caps also impose costs on society by increasing the risk of transmission of tuberculosis ("TB") and strains of HIV that are resistant to current drug therapies. HIV infection is particularly associated with multidrug-resistant TB, which has become a serious public health problem in this country.[27] The CDC has emphasized that prompt diagnosis and treatment of TB in persons with HIV is critical not only to the health of those individuals, but also to prevent the spread of TB, including multidrug-resistant TB, to others with HIV *and without*

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[24] CDC, *Health Insurance Coverage, supra* note 9, at 1084; Gallant, *supra* note 4, at 1021.

[25] Philip Keiser et al., *Protease Inhibitor-Based Therapy Is Associated with Decreased HIV-Related Health Care Costs in Men Treated at a Veterans Administration Hospital*, 20 J. of A.I.D.S. and Hum. Retrovirology 28, 31 (1999); Richard Moore, *HIV Therapy and Prevention: Economics and Cost-Effectiveness*, The Hopkins HIV Report (Sept. 1998) <http://www.hopkins-aids.edu/publications/report/sept98_2.html>; *Cost of Managed HIV Care Remains Stable, Study Says*, AIDS Policy & Law, Oct. 16, 1998, at 15.

[26] Gallant, *supra* note 4, at 1021.

[27] Suzanne H. Donovan, *Tuberculosis and HIV Infection, in AIDS/HIV Reference Guide for Medical Professionals* 193, 193 (John L. Fahey & Diana Shin Flemmig eds., 4th ed. 1997).

HIV.[28] As noted in one guide for medical professionals, "Delays in the diagnosis and treatment of pulmonary TB contribute to increased morbidity, and mortality, *and nosocomial spread* of tuberculosis [i.e., the spread of TB in a hospital or infirmary]."[29] Thus, by discouraging HIV-infected policyholders from regular medical examinations, Mutual's AIDS caps make it more likely that TB will progress, and be transmitted to others, before it is detected.

In addition, as discussed at page 7, *supra*, failure to consistently adhere to an anti-HIV drug therapy poses a danger that the virus will mutate and become resistant to the drugs in question and even to other antiretroviral drugs. A strain of HIV that has become drug-resistant in the host remains drug-resistant if it is transmitted to another person. Therefore, non-adherence to antiretroviral drug therapy is a serious public health threat.[30]

Thus, Mutual's AIDS caps may force HIV-positive policyholders to rely on publicly funded health and cash benefit programs, and may exacerbate serious public health problems. These consequences undermine the ADA's goal of reducing the unnecessary public costs of dependency caused by discrimination.

III. Limiting Coverage of Medical Care Related to a Disability Such as HIV/AIDS Strikes at the Heart of the ADA.

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[28] Centers for Disease Control and Prevention, *Prevention and Treatment of Tuberculosis Among Patients Infected With Human Immunodeficiency Virus: Principles of Therapy and Revised Recommendations*, 47 M.M.W.R. RR-20, at 1, 6, 22, 24 (1998).

[29] Donovan, *supra* note 27, at 196 (emphasis supplied). *See also* Henry F. Chambers, *Tuberculosis in the HIV-Infected Patient, in The Medical Management of AIDS* 353, 353 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999) (discussing documented nosocomial outbreaks of mutidrug-resistant TB resulting from delays in diagnosis and treatment).

[30] Hecht & Chesney, *supra* note 14, at 117.

Mutual's AIDS caps, which Mutual admits have no cost justification, appear to be a clear example of the "unfair and unnecessary discrimination and prejudice" against a stigmatized, vulnerable minority that the ADA was intended to eradicate. 42 U.S.C. § 12101(a)(9); *see also* § 12101(a)(7). Shortly after the ADA was enacted, the Solicitor General characterized AIDS caps as discriminatory under the ADA, in a case involving the legality of an AIDS cap in an employer-sponsored health plan under the Employee Retirement Income Security Act ("ERISA"). In responding to this Court's invitation to state the views of the United States, the Solicitor General concluded that ERISA did not cover the type of AIDS discrimination at issue, but that the ADA *would* apply:

> [T]his case is really about discrimination against persons with AIDS .... The legality of such discrimination ... will undoubtedly be tested in cases arising under the ... ADA ....
>
> Because Congress directly addressed the subject of AIDS discrimination in employee benefit plans under the ADA, claims such as that in issue will likely turn on the requirements imposed on employers under that law.[31]

As noted by the Petitioners in their petition for certiorari, since the enactment of the ADA the Department of Justice and the EEOC have taken the position that HIV/AIDS health insurance caps are covered by ADA Title I (for employer-sponsored fringe benefit plans) and ADA Title III (for policies sold to the general public by insurance companies), and the EEOC has aggressively challenged HIV/AIDS caps in employment-related health insurance plans.

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[31] *Brief for the United States as Amicus Curiae* at 17-18, *Greenberg v. H & H Music Co.*, 503 U.S. 958 (1992) (No. 91-1283), *cert. denied*, 506 U.S. 981 (1992).

Nevertheless, the Court of Appeals below concluded that Mutual's AIDS caps are not discrimination under the ADA because they restrict insurance coverage of a particular illness rather than all insurance for persons with a disability. However, a cap on HIV/AIDS coverage applies to *all* policyholders with HIV infection or AIDS and *only* to those policyholders. It provides policyholders with HIV infection or AIDS with substantially less coverage for their hospitalizations, medical examinations and tests, prescription drugs, and other treatments, than is provided to policyholders who do not have HIV infection. The fact that Mutual has limited all medical coverage related to a targeted disability, rather than all medical coverage for policyholders with that targeted disability, does not make its practice less discriminatory. The cap is still a limitation that applies only to a class of policyholders defined by a disability. Mutual's AIDS cap clearly is disability-based discrimination, particularly in light of the "comprehensive view of the concept of discrimination advanced in the ADA" that this Court recognized in *Olmstead*, 119 S. Ct. at 2186.

Mutual's AIDS caps are discriminatory even under the definition of discrimination adopted by the dissenting Justices in *Olmstead*: "differential treatment" "of otherwise similarly situated persons who are in different groups by reason of certain characteristics provided by statute." 119 S. Ct. at 2194-2195, (Thomas, J., dissenting). Many of the same diseases that occur in persons with HIV also occur in persons without HIV infection, particularly persons with compromised immune systems from chemotherapy or radiation therapy, chronic steroid therapy, organ transplantation, or other factors. Because of the AIDS cap, Mutual treats differently two policyholders who have the same disease, solely on the basis of HIV-status. For instance, Mutual admitted that a policyholder's expenses related to the care and treatment of pneumonia are subject to a cap if and only if the pneumonia is a complication of HIV. (Pet. App. 21a.) Other diseases which are considered HIV-

related, but which also afflict HIV-negative immunocompromised persons, and which often even afflict immunocompetent persons, include tuberculosis;[32] lymphoma and cervical cancer;[33] gynecological infections and pelvic inflammatory disease;[34] herpes simplex virus;[35] shingles;[36] and Hepatitis B and C,[37] to name just a few. In addition, many medical problems caused by anti-HIV medications also occur in persons without HIV infection, including anemia, pancreatitis, diabetes, hyperglycemia and heart disease.[38]

The Court of Appeals acknowledged that "as the immune system collapses because of infection by HIV, the patient becomes subject to opportunistic infection ... by a host of diseases to which people not infected with HIV are subject." (Pet. App. 7a.) The lower court reasoned, however, that because these infections are more lethal in a person without a strong immune system, "they are not really the same disease" in persons with HIV/AIDS as in persons without HIV infection. (*Id.*) The lower court's attempted

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[32] Chambers, *supra* note 29, at 353-354.

[33] Lawrence D. Kaplan & Donald W. Northfelt, *Malignancies Associated With AIDS, in The Medical Management of AIDS* 467, 467, 489 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[34] Meg D. Newman & Constance B. Wofsy, *Women and HIV Disease, in The Medical Management of AIDS* 537, 544-47 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[35] W. Lawrence Drew *et al., Management of Herpesvirus Infections (Cytomegalovirus, Herpes Simplex Virus, and Varicella-Zoster Virus), in The Medical Management of AIDS* 429, 438 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[36] *Id.* at 446.

[37] Andrew H. Talal & Douglas T. Dieterich, *Gastrointestinal and Hepatic Manifestations of HIV Infection, in The Medical Management of AIDS* 195, 203-204 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[38] Deeks & Volberding, *supra* note 10, at 106-09; Shantel M. Mullin et al., *Antiretroviral Adverse Effects and Interactions: Clinical Recognition and Management, in The Medical Management of AIDS* 79, 79-83 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

distinction has no basis in medical science. A disease is defined by its etiologic agent(s), associated laboratory findings, and clinical signs and symptoms.[39] Medical authorities classify a number of diseases that occur in persons without HIV as HIV-related or AIDS-related because they occur much more frequently, and tend to be more virulent, in HIV-infected patients than in patients with normal immune systems,[40] not because, e.g., cancer or pneumonia or tuberculosis is a "different disease" in a patient with HIV/AIDS.[41] Even PCP, an AIDS-defining illness which the lower court asserted is "distinctive" to HIV (Pet. App. 7a), is the same disease when it occurs in patients whose immune systems have been impaired by organ transplantation, tumor growth (neoplasia), or malnutrition.[42]

As Judge Evans observed in his dissent below, "as Mutual of Omaha concedes, ... coverage for certain expenses would be approved or denied based solely on whether the insured had AIDS." (Pet. App. 17a.) In many instances, therefore, AIDS caps treat similarly situated individuals

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[39] *E.g., Steadman's Concise Medical Dictionary for the Health Professions* 242 (John H. Dirckx ed., 3d ed. 1997); *Taber's Cyclopedic Medical Dictionary* 556 (17th ed. 1993) (definitions of "disease").

[40] *See, e.g.*, Kaplan & Northfelt, *supra* note 36, at 467, 489; Kathryn Kocurek & Harry Hollander, *Primary and Preventive Care for the HIV-Infected Adult, in The Medical Management of AIDS* 125, 130 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

[41] *See, e.g.*, John G. Bartlett, *Other HIV-Related Pneumonias, in The Medical Management of AIDS* 331, 332, 334 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999) (HIV-related pneumonias have similar clinical presentations in HIV-infected and HIV-negative patients); Chambers, *supra* note 31, at 353, 354 (tuberculosis, caused by *Mycobacterium tuberculosis*, presents similarly in patients without HIV and in patients with early-stage HIV infection, and can be transmitted from HIV-positive to HIV-negative persons); Fauci & Lane, *supra* note 8, at 1833 (standard therapy for tuberculosis is generally as successful in the HIV-infected patient as in the HIV-negative patient).

[42] *See* Laurence Huang & John D. Stansell, *Pneumocystis carinii Pneumonia, in The Medical Management of AIDS* 305, 305 (Merle A. Sande & Paul A. Volberding eds., 6th ed. 1999).

differently, solely on the basis of disability – a classic example of discrimination.

IV. This Case Presents a Good Opportunity to Resolve the Uncertainty Over the Legality of AIDS Caps Under the ADA.

Section 501(c) of the ADA, 42 U.S.C. § 12201(c), permits an insurer to restrict coverage of a disability if it costs more, based on actuarial studies and/or claims experience, or if State law otherwise permits the restriction in question. Mutual, however, "stipulated that [it] has not shown and cannot show that its AIDS caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law." (Pet. App. 22a-23a.) Mutual's stipulations are consistent with industry-wide data on the cost of treating HIV/AIDS relative to the costs of other illnesses. Resolution of the legal questions presented by this case, therefore, should resolve the larger question of the legality under the ADA of AIDS caps generally.

A 1998 study by the Health Insurance Association of America ("HIAA") and American Council of Life Insurance ("ACLI") documents substantial declines in AIDS related health insurance claims over the past few years. American Council of Life Insurance and Health Insurance Association of America, *AIDS-Related Insurance Claims Paid in 1997*, 1 AIDS Reference Guide (Atlantic Info. Services, Inc.) ¶316 (Nov. 1998). Commenting on an earlier (1995) study by HIAA and ACLI of AIDS claims paid by insurers, an editorial in a publication for corporate risk managers and employee health plan administrators declared:

> Back in the 1980s some employers rewrote their health care policies to put in separate and much lower coverage limits for AIDS than for other medical conditions. Employers that put in those

> lower limits justified their actions by saying that the cost of AIDS claims could threaten the solvency of their health care programs.
>
> Such actions seem totally unjustified given the declining cost of AIDS claims. ...
>
> * * *
>
> [T]he results [of the 1995 HIAA-ACLI study] ... suggest ... that the cost of covering AIDS is manageable and that the cost is not going to bankrupt insurers or employers.

AIDS Claim Fears Unfounded, Business Insurance, Aug. 28, 1995, at 8.

Moreover, the record in this case contains unrebutted testimony about industry-wide coverage costs by Dr. Fred Hellinger, a leading expert on HIV/AIDS treatment costs, and Professor Mark J. Browne, an actuarial expert. They testified that the cost of treating HIV/AIDS is comparable to or less than the costs of treating other severe medical conditions. (Pet. App. 49a (Dr. Hellinger), 44a (Professor Browne).) This testimony is consistent with the current literature.[43] When HIV/AIDS health insurance caps have been challenged in litigation under the ADA, e.g., by the EEOC, the insurers for the most part have readily dropped the caps.[44]

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[43] *See, e.g.*, Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers Under the ADA and ERISA*, 35 Tort & Ins. L. J. 117, 132-33 (1999) (comparing costs of AIDS to other health conditions).

[44] *See* United States Equal Employment Opportunity Commission, *EEOC Docket of ADA Litigation as of March 31, 1998*, Trial Docket – Resolved Cases (visited November 9, 1999) <http://www.eeoc.gov/docs/ada98/txt> (14 trial-level challenges to AIDS caps in employer-sponsored group health plans were brought between 1993 and 1997; in

The lower court's decision may encourage a resurgence of HIV/AIDS health insurance caps. Even though the cost of HIV/AIDS is comparable to or less than the cost of many other serious health conditions, persons with HIV and AIDS are still stigmatized and viewed by many as "others" whose medical costs are not comparable to the needs of persons with cancer, heart disease, or other "normal" medical conditions.[45] Therefore, health insurers are able to reduce payouts and increase profits by imposing HIV/AIDS caps without arousing the type of opposition that they might expect if they were to cap benefits for cancer, heart disease, or cystic fibrosis, for example.

Moreover, because of the Court of Appeals' decision, patients and health care providers now will be less certain of the legality of health insurance AIDS caps when they encounter them. Doctors and patients who believe the caps to be illegal will nonetheless be forced to treat the caps seriously, and will face the dilemma of how to allocate the limited insurance coverage for HIV care. Clarity is urgently needed on this matter. Because few if any insurers will be able to demonstrate a cost-based justification under ADA Section 501(c), resolution by the Court of the questions presented in this case would provide the certainty that persons with HIV and their health care providers need.

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each case, the cap was dropped and /or the plan sponsor paid damages to individuals whose claims had been denied or to their estates).

[45] Samuel A. Marcosson, *Who is "Us" and Who is "Them" -- Common Threads and the Discriminatory Cut-Off of Health Care Benefits for AIDS Under ERISA and the Americans With Disabilities Act*, 44 Am. U. L. Rev. 361, 363-65 (1994). *See also* Mansfield, *supra* note 44, at 119, 133 & n.83 (review of the case law indicates that other health conditions have not been subjected to insurance caps similar to those imposed on HIV/AIDS); *Carparts Dist. Center, Inc. v. Automotive Wholesaler's Ass'n of New England, Inc.*, 987 F. Supp. 77, 82 (D. N.H. 1997) (discussing evidence of bias motivating decision to institute AIDS cap in group health plan). *See generally* Gregory M. Herek, *AIDS and Stigma*, 42 Am. Behav. Sci. 1106, 1108, 1109 (1999) (discussing belief held by many that persons with AIDS deserve their condition).

CONCLUSION

The petition for a writ of *certiorari* should be granted.

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APPENDIX: STATEMENTS OF INTEREST OF *AMICI CURIAE*

The Infectious Diseases Society of America represents more than 5,000 physicians, scientists and other health professionals dedicated to excellence in patient care, research and public health disease prevention and education in the field of infectious diseases. Infectious diseases is a board certified subspecialty of internal medicine and pediatrics. The majority of persons with HIV and AIDS in this country receive care from infectious diseases physicians.

The National Alliance of State and Territorial AIDS Directors ("NASTAD") is the only national public health organization in the United States that focuses exclusively on the HIV/AIDS epidemic. Founded in 1992, the organization represents the chief HIV/AIDS program administrators who are responsible for managing federally funded and State funded HIV/AIDS prevention, health, and housing programs in every state. State AIDS directors administer HIV prevention and surveillance programs funded by the Centers for Disease Control and Prevention, and they coordinate the administration of the federal Ryan White CARE Act Title II programs and AIDS drug assistance programs, which organize systems of health care for low-income individuals with HIV disease in every state.

NASTAD has consistently opposed discrimination against individuals with HIV infection. Discrimination represents a barrier to achieving federal, state and local goals in reducing the spread of HIV and in providing compassionate and effective health care services to individuals who are HIV-infected. NASTAD believes that HIV/AIDS caps in private insurance pose a significant financial burden on already strained public health systems, by forcing people living with HIV/AIDS to depend upon public health care benefit programs like state AIDS drug assistance programs and Medicaid. NASTAD is also

concerned that HIV/AIDS caps inappropriately pressure policyholders with HIV to cut corners in their healthcare and increase their risk of non-adherence to therapies and deterioration of their health status. NASTAD believes that these results contradict the ADA's stated goal of reducing the unnecessary public costs of dependency caused by discrimination.

The National Association of Public Hospitals and Health Systems ("NAPH") represents more than 100 metropolitan area safety net hospitals and health systems nationwide. NAPH member institutions serve a large proportion of the nation's HIV/AIDS populations in both inpatient and outpatient settings. In addition to providing medical care to persons with HIV and AIDS, NAPH has historically supported and advocated for the rights of these persons.

The American Nurses Association ("ANA"), a national labor and professional organization for registered nurses, consists of 53 state and territorial constituent organizations with approximately 180,000 members. ANA has been at the forefront in advocating for full non-discriminatory access to health care treatment for all individuals.

The HIV Quality Care Network -- a project of the Infectious Diseases Society of America -- consists of approximately 250 HIV care programs across the country offering health care services to adults and children living with HIV disease. Collectively, the HIV care organizations it represents serve approximately 138,000 patients – 41 percent of the estimated 335,000 individuals with HIV infection that are currently in care in the United States. The Network was formed as a response to a changing health care environment that frequently poses challenges and barriers to health care providers committed to the provision of high-

quality comprehensive health care to HIV-infected patients. As a national network of HIV clinical programs, the Network has a strong interest in health care financing policies and their impact on HIV medical care. Insurance policies that impose arbitrary financial caps on HIV treatment coverage undermine the ability of experienced HIV providers to provide the standard of care for HIV infection that has resulted in the dramatic reductions in HIV mortality and morbidity seen in recent years.

The American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, representing over 50,000 public health professionals. It represents all disciplines and specialties in public health. APHA also publishes a technical report series dealing with various aspects of the HIV epidemic through the *American Journal of Public Health*, as well as numerous books related to HIV and state-of-the-art scientific research. APHA supports the goal of equalization of opportunities for disabled persons in every facet of life.